**NORTHWOODS THERAPY PATIENT REGISTRATION PLEASE FILL IN ALL INFORMATION COMPLETELY**

PATIENT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE \_\_\_\_\_\_\_\_\_ ZIP\_\_\_\_\_\_\_\_\_\_\_\_\_

CELL PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BIRTHDATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MALE\_\_\_\_\_\_\_\_ FEMALE \_\_\_\_\_\_ EMPLOYER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL REFERRING DOCTOR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME OF RESPONSIBLE PARTY/ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(if different from above)(THIS WOULD BE WHERE BILLS ARE SENT)

CHECK THE CORRESPONDING BOX TO CHOOSE FROM A TEXT MESSAGE OR VOICE REMINDERS FOR APPOINTMENTS:

 TEXT REMINDER VOICE REMINDER NO REMINDER

HOW DID YOU HEAR ABOUT US? (mark corresponding option)

 WEBSITE\_\_\_\_\_\_\_\_\_\_\_ ADVERTISING\_\_\_\_\_\_\_\_\_\_DOCTOR\_\_\_\_\_\_\_\_\_RETURN PATIENT\_\_\_\_\_\_\_\_\_

 SOCIAL MEDIA\_\_\_\_\_\_\_\_\_FAMILY / FRIEND\_\_\_\_\_\_\_\_\_\_\_OTHER (explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IS THIS CONDITION WORK-RELATED? YES / NO AUTO ACCIDENT? YES / NO

IS YOUR COMP CLAIM BEING DENIED? YES / NO

IF YES, DATE OF ACCIDENT

DATE OF INJURY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STATE WHERE OCCURRED

PRIMARY INSURANCE:

NAME OF PERSON WHO CARRIES THE INSURANCE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB \_\_\_\_\_\_\_\_\_\_\_\_\_

NAME OF EMPLOYER

SECONDARY INSURANCE: INSURED’S NAME**­­**­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_

**IF TRICARE/VA PLAN, SOC SEC #**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Name: Phone Number: Relationship to Patient:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF INFORMATION AND BILLING**

I authorize Northwoods Therapy, their physicians, and other personnel to discuss my health and billing information, in person or by telephone, with the following family members or friends involved in my medical care. This authorization will remain in effect for an unlimited amount of time unless otherwise noted or revoked.

Name: Relationship to patient:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I hereby authorize my insurance benefits to be paid directly to NORTHWOODS THERAPY ASSOCIATES, realizing I am responsible for any charges remaining after payment of insurance benefits and for any non-covered services. I also hereby authorize the release of pertinent medical information to insurance carriers for the purpose of payment or determination of benefits.**

**Copies of the Written Notice of Privacy Practice from NORTHWOODS THERAPY ASSOCIATES are available to me in the waiting room or upon my request.**

**Patient or Personal Representative Signature Date**